

(PROVIDER ORGANIZATION)
FINANCIAL AUTHORIZATION
FOR APPLICATION AND MANAGEMENT OF ENTITLEMENTS AND BENEFITS

I hereby authorize the _____
(Provider Organization)

to research and apply for any and all financial aid available to

_____, not to exceed the cost of services rendered
(Client Name)

by the South Carolina Department of Disabilities and Special Needs.

Financial Aid referred to in this document includes, but is not necessarily limited to, Social Security, Title XIX - Medicaid, VA Pension, Health Insurance, and CHAMPUS.

Signature of Parent/Guardian/
Other Responsible Party

Signature of Resident

Relationship to Client

Address

City, State Zip Code

Telephone Number

Sworn before me on this _____ day

of _____ 19__.

NOTARY PUBLIC FOR SOUTH CAROLINA

My Commission Expires_____